



**THE COMMONWEALTH OF MASSACHUSETTS  
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES  
DEPARTMENT OF PUBLIC HEALTH  
BUREAU OF HEALTH PROFESSIONS LICENSURE  
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BOSTON, MA 02114  
617-973-0806**

<https://www.mass.gov/orgs/bureau-of-health-professions-licensure>

**BOARD OF REGISTRATION OF PHYSICIAN ASSISTANTS**

**CHANGE IN SUPERVISING PHYSICIAN**

Complete this form and submit it to the Board within 30 days if you are:

If you are reporting changes in more than one work setting, you must complete and submit a separate form for each supervising physician in each work setting.

Please check the appropriate box:

- ☐ Adding a new supervisory physician
- ☐ Replacing your current supervising physician
- ☐ Adding an additional supervising physician
- ☐ Terminating a supervising physician
- ☐ Change of Work Setting Information

**Section I : Physician Assistant Information**

Name : \_\_\_\_\_  
Last First Middle License #  
Address : \_\_\_\_\_  
Number Street City/Town State Zip

**Section II : Change Request Information**

\_\_\_\_\_ **Adding new supervising physician:**

New Supervising Physician: \_\_\_\_\_  
Last First MI License #

Facility Name : \_\_\_\_\_

Facility Type : ☐ Office ☐ Clinic ☐ Hospital ☐ Other : \_\_\_\_\_

Employment Type : ☐ Full-Time ☐ Part-Time ☐ Per Diem ☐ Other: \_\_\_\_\_

Address : \_\_\_\_\_  
Street City State Zip

Effective Date: \_\_\_\_\_

\_\_\_\_\_ **Replacing supervising physician:**

Previous Supervising Physician: \_\_\_\_\_  
Last First MI License #

Termination Date: \_\_\_\_\_

New Supervising Physician : \_\_\_\_\_

Facility Name : \_\_\_\_\_

Facility Type : ☐ Office ☐ Clinic ☐ Hospital ☐ Other : \_\_\_\_\_

Employment Type : ☐ Full-Time ☐ Part-Time ☐ Per Diem ☐ Other: \_\_\_\_\_

Address : \_\_\_\_\_  
Street City State Zip

Effective Date: \_\_\_\_\_

\_\_\_\_\_ **Adding additional supervising physician:**

New Supervising Physician: \_\_\_\_\_  
Last First MI License #

Facility Name : \_\_\_\_\_

Address : \_\_\_\_\_  
Street City State Zip

Facility Type : ☐ Office ☐ Clinic ☐ Hospital ☐ Other : \_\_\_\_\_

Employment Type : ☐ Full-Time ☐ Part-Time ☐ Per Diem ☐ Other: \_\_\_\_\_

Effective Date: \_\_\_\_\_

\_\_\_\_\_ **Terminating supervising physician:**

Physician Name: \_\_\_\_\_  
Last First MI License #

Termination Date: \_\_\_\_\_

**Clinical setting :** Please check all areas of practice that apply:

- |   |   |
|---|---|
| <input type="checkbox"/> Adminsitration     | <input type="checkbox"/> General Surgery        |
| <input type="checkbox"/> Adolescents        | <input type="checkbox"/> Occupational Health    |
| <input type="checkbox"/> Clinical Research  | <input type="checkbox"/> Pediatrics             |
| <input type="checkbox"/> Emergency Medicine | <input type="checkbox"/> Primary Care           |
| <input type="checkbox"/> Education          | <input type="checkbox"/> Obstetrics/Gynecology  |
| <input type="checkbox"/> Internal Medicine  | <input type="checkbox"/> Other (Please Specify) |
| <input type="checkbox"/> Genral Medicine    |   |
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**Section III : To be filled out by Supervising Physician**

**If you answer YES to any of the questions below, please submit a separate sheet with a detailed explanation.**

Have you [the supervising physician] been disciplined [as defined by the Board of Registration in Medicine regulations] by any government authority, hospital or health care facility or professional medical association [international, national or local] within the past ten years from the date of this application?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

Within the last ten years from the date of this application, have you ever had staff privileges, employment or appointment in a hospital or health care institution denied, suspended or revoked?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

Within the last ten years from the date of this application, have you ever resigned from a medical staff in lieu of disciplinary action or has any quality assurance committee suggested any form of corrective action concerning your practice?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

I understand that, notwithstanding any other provisions of law, a physician assistant may perform medical services when such services are rendered under my supervision. Such supervision shall be in conformance with Board regulations at 263 CMR 5.04 and 5.05.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature of Supervising Physician

\_\_\_\_\_  
Date

**A MA Board of Registration in Medicine Physician Profile must be attached. Profiles are available on line at [www.massmedboard.org](http://www.massmedboard.org). Send the profile and the completed form to the MA Board of Physician Assistants at the address above. Make a copy for your records. You will not receive confirmation of receipt by the board.**